STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RIVERBEND	2715 CHARLESTOWN PIKE JEFFERSONVILLE, IN 47130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00405215. Complaint IN00405215 - State deficiency related to the allegations is cited at R0060. Survey dates: April 4 and 5, 2023. Facility number: 010885 Residential Census: 91 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on April 10, 2023.	R 0000		
R 0060 Bldg. 00	410 IAC 16.2-5-1.2(dd) Residents' Rights - Deficiency (dd) The facility shall provide reasonable access to any resident, consistent with facility policy, by any entity or individual that provides health, social, legal, and other services to any resident, subject to the resident ' s right to deny or withdraw consent at any time. Based on observation, record review, and interview, the facility failed to ensure a resident received appropriate nail care for 1 of 3 residents reviewed. (Resident C) Findings include: The clinical record for Resident C was reviewed on 4/4/23 at 10:26 a.m. The resident's diagnoses included, but were not limited to, type 2 diabetes mellitus, peripheral vascular disease, long term	R 0060	This Plan of Correction is submitted as required under State law. The submission of this Plan of Correction does not constitute an admission on the part of [Riverbend] as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. The submission of this Plan of Correction does not constitute an admission that the findings	04/28/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
William Gregory Jackson	Executive Director	05/15/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	use of anticoagulants, and neuropathy. The resident's service plan, dated 3/27/23, indicated the resident required moderate physical assistance of staff with personal hygiene and grooming. The resident's shower sheets indicated the following: - On 10/29/22 the resident refused his shower. He needed his toenails cut. There was no documentation of nail care being provided. - On 1/27/23 the resident refused his shower and needed his toenails cut. There was no documentation of nail care being provided. - On 1/31/23 the resident received a shower. He needed his toenails cut. There was no documentation of nail care being provided. - On 2/1/23 the resident received a shower. The documentation did not indicate whether or not the resident needed his toenails cut, and did not address any nail care. - On 3/11/23 the resident refused his shower and needed his toenails cut. There was no documentation of nail care being provided. - On 3/18/23 the resident refused his shower and needed his toenails cut. There was no documentation of nail care being provided. - On 3/28/23 the resident received a shower. He needed his nails cut. There was no documentation of nail care being provided. The clinical record lacked documentation of any		constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures, as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any judicial and/or administrative proceeding on that basis. The Community also submits this Plan of Correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney or shareholder of the Community or affiliated companies. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; 3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; 4. How the corrective action(s) will be monitored to ensure the	

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	filing or trimming of the resident's nails prior to 3/30/23, or any attempts to obtain a podiatry consult prior to 3/24/23. During an observation on 4/4/23 at 10:51 a.m., Resident C's bilateral thumb nails were approximately one-half of an inch long, very thick and yellowed. His toenails were very thick and yellowed, with several of his toenails observed to be curling sideways into adjacent toes. During an interview on 4/4/23 at 11:12 a.m., the DON (Director of Nursing) indicated residents were offered podiatry services when they first admitted. It would be documented if they signed up for it. Resident C was on VA (Veteran's Affair) insurance and a lot of times resident's with this insurance declined services due to VA not paying for the service. She provided a form, dated 3/29/23, where the resident's POA (Power of Attorney) did sign the consent for for podiatry services on 3/29/23. During an interview on 4/4/23 at 12:15 p.m., the DON provided a consent form for podiatry services for Resident C, which was undated, and unsigned. The form had "VA" written on it in pink highlighter. The DON indicated this was how his consent form had been filled out, and she did not know if he had been set up with VA podiatry or not. She was not sure if anyone had addressed his nails. She was not aware his toenails were curling. On the shower sheet they documented if they needed toenails cut and the nurse could attempt to try to file them down a bit or cut them. During an interview on 4/4/23 at 12:32 p.m., Resident C's family member indicated he had recently visited the resident and found his toenails were all curled up. He personally cut the		deficient practice will not recur, i.e., what quality assurance program will be put into place; and 5. By what date the systemic changes will be completed. The facility is required to submit a POC for the state deficiencies no later than April 26, 2023. R060 1. Resident C is now receiving appropriate nail care from a podiatrist. Resident C will see the podiatrist at least once every 90 days. Going forward staff will assess Resident C's nails weekly for 4 weeks then monthly for 5 months, and contact the podiatrist as needed. 2. The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 3. The Wellness Director or designee will conduct an in-service on documentation for all licensed staff. In addition, the Wellness Director or designee will audit all residents to ensure that podiatry services are set up and/or a plan for the residents that refuse is documented. 4. The Wellness Director or designee will audit 5 random resident charts weekly for the first three months and then monthly for	

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	resident's fingernails but the two thumbs he left alone and told the nurse because they had crust in them. He was concerned the resident's nails needed cut and he wasn't sure if it was being addressed. During an interview on 4/5/23 at 9:52 a.m., CNA (Certified Nurse Aide) 3 indicated she cared for the resident often, but she could not speak on his nail care. He was a diabetic and CNA's could not perform nail care on diabetics. The nurses did his nails as far as she knew. They did document on the shower sheet if they needed care and gave it to the nurses. During an observation on 4/5/23 at 9:55 a.m., CNA 3 removed the resident's socks and shoes. On his left foot, his pinky, fourth and third toenails were approximately one-quarter of an inch long and curling left into the adjacent toes. His second toe was approximately one-quarter of an inch thick and curling up, and his great toe was approximately one-quarter of an inch thick and curling into the second toe. She did not know how long his toenails had looked like that. She didn't know they looked like that. She was not sure how long it would take. On his right foot, the great and second toes were approximately one half of an inch long and curling under and into the adjacent toes. His third, fourth, and fifth toes were approximately one-quarter of an inch long, thick, yellow, and curling into the adjacent toes. During an interview on 4/5/23 at 10:01 a.m., LPN (Licensed Practical Nurse) 4 indicated no one had informed her of the state of the resident's nails and they did not provide nail care for him. During an interview on 4/5/23 at 10:03 a.m., LPN 5 indicated they did not provide nail care for the		another three months to ensure compliance. 5. Corrective Date April 28, 2023	

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	resident that she knew of. They did filing, but as far as she knew they weren't clipping the resident's nails. She had not seen his toenails. When the CNA checked their nails needed clipped on the shower sheet, they would contact podiatry and call them to come out and check their toes out. She would go in and assess for herself. She did not recall ever doing that for him. They definitely looked like they needed to be seen by the podiatrist. She did not know how long they ' d been like that and did not know how long it would take for them to look like that. They were capable of filing his nails. He would benefit from that she thought. During an interview on 4/5/23 at 10:08 a.m., CNA 6 indicated she had seen his nails but he was a diabetic. She had seen them curling under a little bit, but didn't think she marked that he needed them clipped on his shower sheets. She usually just let the nurse know. She believed she'd let the nurse know before. She didn't know how long his nails had looked like that. During an interview on 4/5/23 at 11:45 a.m., the DON indicated since the resident was a diabetic they would not cut his nails, but they could file them down. They did not have anything signed by the POA declining podiatry services. The CNAs were to look at the nails and report to the nurse their findings. The nurse would then attempt to get them on the podiatrist, or potentially call the family and tell them. The most current Health Related Services Policy, last revised 8/17, provided on 4/5/23 at 11:45 a.m., by the DON, included, but was not limited to, "... 2. Factors associated with foot and toenail care: Age, poor fitting footwear, preexisting conditions, disease, injury, or poor hygiene all can cause			

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	increased foot and/or toenail problems. Poor circulation and limited mobility may also increase the need for foot and toenail care... Note: For elderly Residents with diabetes -- especially those with circulation problems-- the WELLNESS DIRECTOR must develop a appropriate plan for nail care to be provided, (podiatrist) Unlicensed Community Team Members may not assist with the nail care of such Residents. THIS MUST BE INDICATED IN THE Resident's SERVICE PLAN... Check the Resident's toenails once a month and clip the toenails either monthly or every other month, depending on their growth... Refer the resident to a podiatrist if the Resident's toenails are too thick or deformed to be cared for by designated Community Team Members..." This State tag relates to Complaint IN00405215.			